



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3D

CERTIFICATE OF DEATH

04214 353
Reg. Dist. No.

1. PLACE OF DEATH:

County Worcester
City or town Bishop Md. Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Eva Katie Bunting4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife John R. Bunting7. Birth date of deceased (mo., day, yr.) 1872 6.(c) If alive, give age 76 years8. AGE: Years 74 Months Days If less than one day hrs. min. 9. Birthplace Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George Baker13. Birthplace 14. Maiden name Ella Holloway15. Birthplace 16. Informant John R. BuntingAddress Bishop, Md.17. Burial Date thereof Apr. 14, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Red Meis CemLocation Leibyville, Del.18. Funeral director Margarette N. WatsonAddress Pocomoke City, Md.19. Apr. 13 19 46 A. W. Hendrick
(Date rec'd by registrar) 15. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WorcesterCity or town Bishop (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946 at 6:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946 to April 10, 1946 and that I last saw her alive on April 10, 1946Immediate cause of death Central Hemorrhage DURATION 11 days

Due to. _____

Due to. _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of. _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

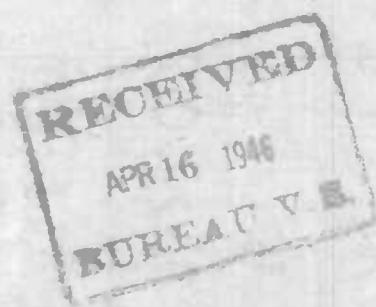
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE. E. E. James

M. D. or other

Address Bishop, Del. Date signed 4-13-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(BPD)

CERTIFICATE OF DEATH

04215

351

Reg. Dist. No.

1. PLACE OF DEATH: Meyester
 County: Snow Hill
 City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, institution, or street address where death occurred: Snow Hill

How long in hospital or institution? _____

3. (a) FULL NAME: Maggie Collick

4. Sex: Female 5. Color or race: Colored 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife: James Collick 8. (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 1854

8. AGE: 93 Years 0 Months 0 Days If less than one day: 0 hrs. 0 min.

9. Birthplace: Snow Hill, Worcester, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

12. Name: Unknown

13. Birthplace: "

14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Marys Great Welfare Board

Address: Snow Hill, Md.

17. Burial: Burial Date thereof: April 27, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. Herby

Location: Snow Hill, Md.

18. Funeral director: Pearce & Adams

Address: Snow Hill, Md.

19. 4/27/1946 Robert L. La Mar, M.D. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester
 City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION) 70

2. (a) If veteran, name war: _____

3. (b) Social Security Number: None

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 1946 at 7 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16, 1945 to April 25, 1946 and that I last saw her alive on April 25, 1946.

Immediate cause of death: Congestive Cardiac Failure DURATION 2 weeks

Due to: Cardiovascular Hypertension Renal Syndrome DURATION 10 yrs

Due to: _____

Other conditions: Rectal Hemorrhage (Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

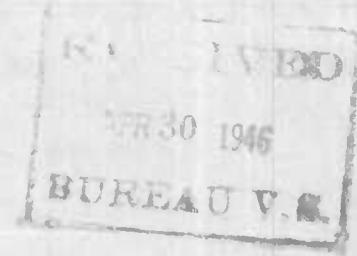
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE: Robert L. La Mar, M.D. M. D. or other: _____

Address: Snow Hill Date signed: 4/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

04217

CERTIFICATE OF DEATH

Reg. Distr. No. 355

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lettie Ellen Carey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widowed

6. (b) Name of husband or wife.....

Thomas Carey

7. Birth date of deceased (mo., day, yr.)

Feb. 27, 1876

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

70

2

3

hrs. min.

9. Birthplace.....

Worcester Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

FATHER

12. Name.....

John Henry Hudson

13. Birthplace

Oakwood

MOTHER

14. Maiden name.....

Lettie

15. Birthplace

Oakwood

16. Informant.....

Robert Carey

Address

Grand Hotel, South River

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof.....

(month)

(day)

(year)

Cemetery or crematory

Whaleyville Cemetery

Location

Whaleyville, Md.

18. Funeral director.....

Mrs. M. Parker Watson

Address

Selbyville, Del.

19. May 2, 1946

Helen F. Haywood

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30-1946 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-18-1946 to 4-30-1946

and that I last saw her alive on 4-30-1946

Immediate cause of death.....

Labor
Pneumonia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

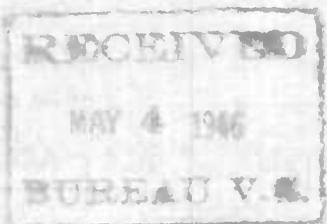
Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Berlin Md. Date signed 5-2-46



PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7420

04216

Reg. Dist. No. 351

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Whitton
 County: Whitton (near)
 City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Benjamin Thomas Davis
 4. SEX Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Widower

8. (b) Name of husband or wife Anna Kate Davis

7. Birth date of deceased (mo., day, yr.) Dec. 14-1859 8. (c) If alive, give age Dead years

8. AGE: 86 Years 3 Months 19 Days If less than one day hrs. min.

9. Birthplace: Whitton md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

12. Name: Benjamin Davis

13. Birthplace: Whitton Md.

14. Maiden name: Sallie Jones

15. Birthplace: Whitton Md.

16. Informant: Mr. Dennis Collins

Address: Delmar Road, Salisbury Md.

17. Burial, cremation, or removal: Burial Date thereof: April 8-46

(Burial, cremation, or removal. Which? (month) (day) (year))

Cemetery or crematory: Whitton Cemetery

Location: near Somerville Md.

18. Funeral director: Hollingshead & C. Walter R. Hollingshead

Address: Salisbury Maryland

19. (Date rec'd by registrar) 4/8/46 13. (Date rec'd by registrar) 4/8/46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: MD County: Salisbury
 City or town: Delmar Road (If outside city or town limits, write RURAL and give nearest town)
 Street No.: (If rural, give LOCATION)

2. (a) If veteran, name war: _____

3. (b) Social Security Number: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3-46 at 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19,

and that I last saw him alive on 19.

Immediate cause of death: Coronary Occlusion

Due to: Generalized arteriosclerosis DURATION 30 yrs

Due to: _____

Other conditions: _____

(Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

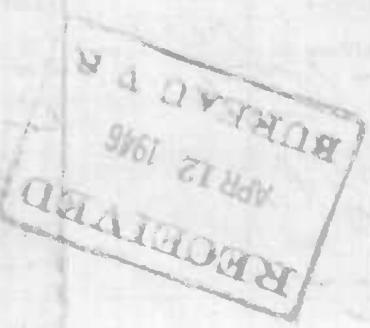
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Where did injury occur? _____ Injured at work? _____

23. SIGNATURE: F. S. Scoll M. D. M. D. or other: _____

Address: Bethel Md. Date signed: 4/8/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The outcome of the case depends especially on the accuracy of the information given. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

04218

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Frances Davis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Married

6. (b) Name of husband or wife

Thomas Davis

7. Birth date of deceased (mo., day, yr.)

May 30, 1894

6. (c) If alive, give age

64 years

8. AGE:

Years Months Days

If less than one day

51

10

17

hrs.

min.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 350

04219

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Worcester

Poconoke

14 day

How long in above place of death?.....
Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Ellen Gunby

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife.....

Chester M. Gunby

7. Birth date of deceased (mo., day, yr.).....
deceased (mo., day, yr.) October 9, 1877

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

68 6 5

hrs. min.

8. Birthplace.....

Whaleyville Worcester County Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

John Powell

13. Birthplace.....

Worcester County

14. Maiden name.....

Hettie M. Williams

15. Birthplace.....

Worcester County

16. Interment.....

Mrs Paul Powell

Address.....

Poconoke City Md

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)

Buckingham Cemetery

Cemetery or crematory.....

Location.....

Berlin, Maryland

18. Funeral director.....

H. Harrison Beadshear

Address.....

Poconoke City Md

19. April 16, 1946

(Date rec'd by registrar)

Ann E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

116 North Main

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

April 14th, 1946, et 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10th, 1946, to 4/14/46.

and that I last saw her alive on April 14th, 1946.

Immediate cause of death.....

Exhaustion.

Due to Cerebral hemorrhage, 4 days.

Due to Hypertension and arterio

sclerosis. Years.

Other conditions..... None.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

R. Lee Haas M. D. or other

Poconoke City, Md. Date signed 4-16-46

Address.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04220

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:

County

Worcester

City or town

Dear Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, Institution, or street address where death occurred:

no

How long in hospital or institution?

no

3. (a) FULL NAME

Georgiana Jones

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

a.s.

Married

6. (b) Name of husband or wife

Lewis Jones

Widowed

7. Birth date of deceased (mo., day, yr.)

about 1878

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

about 67

hrs.

min.

9. Birthplace

Snow Hill Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

MOTHER FATHER

12. Name

Benjamin Harmon

13. Birthplace

Snow Hill Md

14. Maiden name

Emelie Harmon

15. Birthplace

Snow Hill Md

16. Informant

Rev Lewis Jones

Address

Snow Hill Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Apr 16 1946

(month) (day) (year)

Cemetery or crematory

Oberleys

Location

Snow Hill

18. Funeral director

James P. Stewart

Address

Salisbury Md

19. (Date rec'd by registrar)

4/16/46

19 46

Relay Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Worcester

City or town

Snow Hill Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

no

Rd No 2

(If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

4/13/46

19

at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 1945 19 to April 12 1946

and that last saw her alive on 4/12/46 19.

Immediate cause of death

Coronary Thrombosis

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

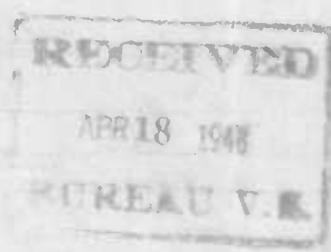
Jane Cohen M.D.

M. D. or other

Address

Snow Hill Md

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 730

CERTIFICATE OF DEATH

04221 855
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Worcester
Bishop's

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

34 yrs.

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

James King

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife.....

Sallie M. King

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age.....

years

Sept 15 1865

8. AGE:

Years

Months

Days

If less than one day

80

7

5

hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Fisher

Farming

11. Industry or business

James King

12. Father

John King

13. Birthplace

Md.

14. Maiden name.....

Sallie (Unknown)

15. Birthplace

Md.

16. Informant.....

Sallie M. King

Address

Bishop's Md. P.T.O.

17. Burial

Burial

(Burial, cremation, or removal: Which?)

Date thereof

April 23 1946

(month)

(day)

(year)

Cemetery or crematory

Evergreen

Location

Baltimore Md.

18. Funeral director

M. Pasha Fatton

Address

Silverville Del.

19. 4-21

1946 Helen F. Hayward

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester

City or town..... Bishop's Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... P.T.O.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 20 1946 at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

11/19 1946 to 1946

and that I last saw him alive on 20th April 1946

Immediate cause of death..... Uremia

DURATION

Due to..... Atherosclerotic Heart Disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. Garrett Hume M.D.

M. D. or other

Address..... Silverville Del. Date signed 4-21-46

RECEIVED

APR 25 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

CERTIFICATE OF DEATH

04222

Reg. Dist. No. 350

1. PLACE OF DEATH:

County

Worcester

City or town

(Unionville) Pocomoke R.F.D. 2. Box 30

How long in above place of death?

About 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harrison Knox

4. Sex

Male

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jobitha Brittingham Knox

7. Birth date of deceased (mo. day, yr.)

September ? 1893

6.(c) If alive, give age 52 years

8. AGE:

Years 52

Months 7

Days

If less than one day

hrs. min.

9. Birthplace

Malden, Vt

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farming.

12. Name

Henry Knox

13. Birthplace

Acco. Co., Vt

14. Maiden name

Elijah Lauer

15. Birthplace

Acco. Co., Vt

16. Informant

Elijah Knox

Address

Pocomoke, Md. R.F.D. 2 Box 30

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 17, 1946
(month) (day) (year)

Cemetery or crematory

Unionville M. Cemetery

Location

Unionville, Md.

18. Funeral director

Edgar Thomas.

Address

Accomac, Virginia

19. Date rec'd by registrar

April 16, 1946

(Date rec'd by registrar)

Anne E. White

Registrar

(If outside city or town limits, write RURAL and give nearest town)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town (Unionville) Pocomoke R.F.D. Box 30

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 14th, 1946, to April 14th, 1946, and that I last saw him alive on April 14th, 1946.

Immediate cause of death Cardiac Failure,

DURATION

Due to Coronary occlusion,

few hours

Due to Arterio-sclerosis,

(?)

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

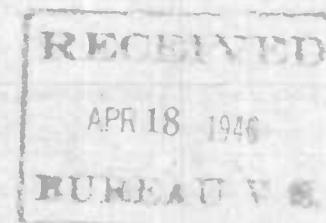
23. SIGNATURE

R. Lee Hale

M. D. or other

Address Pocomoke City, Md.

Date signed 4/15/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 850

CERTIFICATE OF DEATH

Reg. Dist. No. 114223-353

1. PLACE OF DEATH:

County.....

Worcester
Selbyville Del (Rural)

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Amanda Martin

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

Colored

Married

6.(b) Name of husband or wife.....

Ernest Martin

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age..... years

1882

8. AGE:

Years

64

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Md.

(Town, county, and state)

10. Usual occupation.....

Cook

11. Industry or business

Joshua Ward

12. Name.....

Md.

MOTHER FATHER

13. Birthplace.....

Maria Robbins

14. Maiden name.....

Md.

15. Birthplace.....

Bertie Harmon

16. Informant.....

Selbyville, Del.

Address

Burial

Date thereof.....

(month) (day) (year)

4-11-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Cool Spring

Location.....

near Gordonsville, Md.

18. Funeral director.....

Marguerite A. Watson

Address

Pocomoke City, Md.

4/11

4/11 46 Mrs. Fay Berger

(Date rec'd by registrar)

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Md. Worcester

City or town.....

Selbyville Del. Rural

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Apr. 7 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 25 1946 to April 6 1946
and that I last saw her alive on April 6th 1946

Immediate cause of death.....

Cerebral Hemorrhage, 2 days

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings at operation.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

E. James

M. D. or other

Address.....

Selbyville, Del. Date signed 4-9-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04224

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9:45 AM

1. PLACE OF DEATH:

County Worcester
City or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

George Edward McDonald

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife

Maggie McDonald

7. Birth date of deceased (mo., day, yr.)

Jan. 2, 1888

6. (c) If alive, give age 56 years

8. AGE:

Years

Months

Days

If less than one day

58

3

20

hrs.

min.

9. Birthplace

Wilmington Delaware

(Town, County, and State)

10. Usual occupation

Fisherman

11. Industry or business

Samuel McDonald

12. Name

Delaware

13. Birthplace

Katherine Doyle

14. Maiden name

Germany

15. Birthplace

Mrs. George McDonald

16. Informant

I Ocean City, md

Address

Burial

Date thereof 4/25/46

(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory Taylorsville

Location Berlin Md P. L. D.

18. Funeral director Anna P. Burback

Address Berlin Md

19. 4-25 1946 - Helen F. Hayward

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Worcester

City or town

Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 22nd 1946March 1st 1946 to April 22nd 1946and that I last saw him alive on April 22nd 1946

Immediate cause of death

Chronic of Liver

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

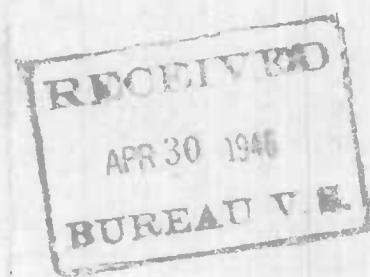
23. SIGNATURE

H. F. Hayward

M. D. or other

Address

Baltimore Md Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 956

04225

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sowell James Nock

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 27, 1918

8. AGE:

Years

Months

Days

If less than one day

27 9

12

hrs.

min.

9. Birthplace

Berlin Worcester

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Gordon Nock

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 4-11

(Date rec'd by registrar)

1946

Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 8 1946 at 104 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 27, 1918 to April 8, 1946

and that I last saw him alive on April 7, 1946

Immediate cause of death

Atherosclerotic heart
disease

DURATION

20 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Baltimore Md. Date signed 17/10/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

CERTIFICATE OF DEATH

04226350
Reg. Dist. No.

1. PLACE OF DEATH:

County Worcester
City or town Pocomoke City and Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie Elizabeth Pennenvee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

Jed Pennenvee

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.) July 4, 1850

8. AGE:

Years
95Months
8Days
28

If less than one day

hrs.

min.

9. Birthplace

Stockton Worcester, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

Thomas Snack

12. Name

Thomas Snack

13. Birthplace

Md.

14. Maiden name

Catherine Pruitt

15. Birthplace

Md.

16. Informant

Grover Pennenvee

Address

Franklin City, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 4, 1946

(month) (day) (year)

Cemetery or crematory Greenback

Location Greenbackville, Va

18. Funeral director Margarete H. Watson

Address Pocomoke City, Md.

19. April 5, 1946
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke City Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2, 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 4, 1850 to April 2, 1946
and that I last saw her alive on April 2, 1946

Immediate cause of death

Disease, degenerative

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. E. C. Gentry
Date signed April 5, 1946

M. D. or other

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19-B

04227

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County

City or town

Pocomoke City Md.

Dorchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

46 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John William Reid

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

married

6.(b) Name of husband or wife

Katherine Reid

7. Birth date of deceased (mo., day, yr.)

Sept 14, 1881

6.(c) If alive, give age

60

years

8. AGE:

Years

Months

Days

If less than one day

64

7

4

hrs.

min.

9. Birthplace

Stockton, Worcester, Md.

(Town, county, and state)

10. Usual occupation

Marshall

11. Industry or business

MOTHER FATHER

John W. Reid

13. Birthplace

Md.

14. Maiden name

Elizabeth Lamberton

15. Birthplace

Md.

16. Informant

Mrs. Katherine Reid

Address

Pocomoke City Md.

17. Burial

Date thereof April 21, 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Bethany M. P. Cemetery

Location

Pocomoke City Md.

18. Funeral director

Henry Goldwater

Address

Pocomoke City Md.

19. April 20, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Pocomoke City Md.

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

(If rural, give LOCATION)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th, 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

From time to time about 4 years.

and that I last saw him alive on April 16th, 1946.

Immediate cause of death Heart failure.

Fell over dead while at dinner.

DURATION

Due to Myocarditis.

Chronic nephritis.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

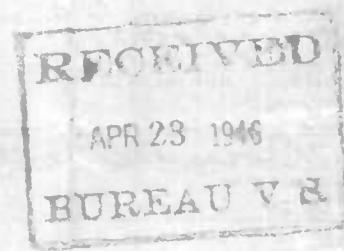
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

R. Lee Haar M. D. another

Address Pocomoke City, Md. Date signed 4/20/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

04228

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Georgianna Shaebley

7. Birth date of deceased (mo., day, yr.)

April 20 / 1861

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Snow Hill, Worcester, Md

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Own Store

12. Name

Lorenzo S. Shaebley

13. Birthplace

Maryland

14. Maiden name

Jane Elizabeth Shaebley

15. Birthplace

Maryland

16. Informant

Miss Evelyn Shaebley

Address

Snow Hill, Md

17. Burial

Burial

Cemetery or crematory

Bates

Location

Snow Hill, Md

18. Funeral director

Name

Address

Snow Hill, Md

19. Date rec'd by registrar

4/24/46

(Date rec'd by registrar)

1946

20. Date of death

April 22

1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 18

1945

to April 22

1946

and that I last saw him alive on April 21

1946

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert L. La May, M.D.

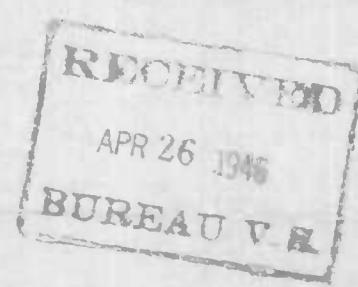
M. D. or other

Address

Snow Hill, Md

Date signed

4/23/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *PP*

14229

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH

Worcester
County
Poconos

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sallie M. Sturgis

4. Sex

Female Colored Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Silar Sturgis

7. Birth date of deceased (mo., day, yr.)

Unknown 1877

6. (c) If alive, give age years

8. AGE: *69* Years

Months — Days — If less than one day — hrs. — min.

9. Birthplace

Poconos Worcester Twp

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Frank Bratten

12. Name

Md

13. Birthplace

Emma Armstrong

14. Maiden name

Md

15. Birthplace

Silar Sturgis

16. Informant

Poconos Twp

Address

Burial April 26, 1946

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Salls Hill

Location

Rural Poconos Twp

18. Funeral director

Burial Association

Address

Poconos Twp

19. April 26, 1946

(Date rec'd by registrar)

Anne E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland Worcester

County Poconos

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 24* 1946, at *29* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on 19...

Immediate cause of death

Due to Starvation

Duration *3 weeks*

Due to Starvation 3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *H. C. Antonius M.D.*

M. D. or other

Address *1700 E. City Md.*Date signed *4/25/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

04230

CERTIFICATE OF DEATH

351

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Worcester

Snow Hill, Rural #

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Hattie Taylor

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Married

6. (b) Name of husband or wife

Thomas Taylor

7. Birth date of deceased (mo. day, yr.)

60 years

8. AGE:

Years

Months

Days

If less than one day

July 5 - 1895

59 9 21 hrs. min.

9. Birthplace.....

Plymouth, North Carolina

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

Housewife

FATHER

12. Name.....

Unknown

13. Birthplace.....

MOTHER

14. Maiden name.....

Unknown

15. Birthplace.....

Thomas Taylor

16. Informant.....

Address Snow Hill, Md. Rural #

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 29/46

(month) (day) (year)

Cemetery or crematory.....

Location Snow Hill, Md.

18. Funeral director.....

Name & firm

Address

Snow Hill, Md.

19. 4/27/46 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill, Rural #

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26

1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October

1945, to

April 26 1946

and that I last saw her alive on April 20 1946

Immediate cause of death

Coronary Thrombosis

DURATION

1 day

Due to

Atherosclerotic Hypertension

unbroken

Heart disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

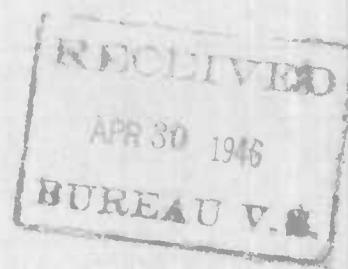
Means of injury

Injured at work?

23. SIGNATURE

Paul Cohen M.D.

Address Snow Hill, Md. Date signed 4/26/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

04231

CERTIFICATE OF DEATH

Reg. Dist. No. 955

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution?.....

no

3. (a) FULL NAME

Charles Remmons

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

a. a.

widower

6. (b) Name of husband or wife

Elizabeth Remmons

Dead

6. (c) If alive, give age no years

7. Birth date of deceased (mo. day, yr.)

about

1868

8. AGE:

Years

Months

Days

If less than one day

18

hrs.

min.

9. Birthplace.....

Berlin

md

(Town, county, and state)

10. Usual occupation.....

Gaffer

11. Industry or business

Same as above

MOTHER FATHER

12. Name.....

Raymond Remmons

13. Birthplace.....

Berlin

md

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Raymond Briddle

Address.....

Berlin

md

17. Burial

Date thereof Apr 14 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Evergreen

Location.....

Berlin

md

18. Funeral director.....

James H. Stewart

Address.....

Berlin

md

19. 4-14

1946

Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 11 46 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18....., to.....

19.....

and that I last saw h.....alive on.....

19.....

Immediate cause of death.....

Cerebral

Due to.....

Hemorrhage

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

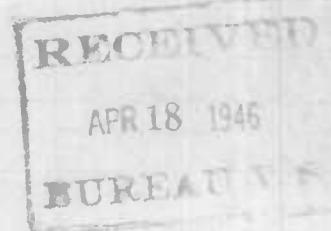
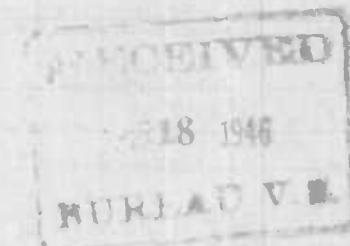
Address.....

Chas. R. Law MD

M. D. or other

(Date rec'd by registrar)

Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H

T

VS A15

1. PLACE OF DEATH:

County

Worcester

City or town

Ocean City MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

no

How long in hospital or institution? no

3. (a) FULL NAME

Frederick Rye

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

a. a.

Married

6. (b) Name of husband or wife

Dont know

Dont know

6. (c) If alive, give age years

about

1907

7. Birth date of deceased (mo. day, yr.)

about

8. AGE: Years Months Days If less than one day

about 39

-

-

hrs. min.

9. Birthplace

W. C. Enfield

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Same as above

12. Name

John Rye

13. Birthplace

Wickhams

14. Maiden name

John Rye

15. Birthplace

Wickhams

16. Informant

Mrs. Mary Rye

Address

Ocean City MD

17. Burial

Date thereof

Apr 12 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Evergreen

Location

Berlin MD

18. Funeral director

James F. Stewart

Address

Salisbury MD

19. 4-12 1946 Helen F. Haywood

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County Worcester

City or town

Ocean City MD

Street No.

785 Wildmico

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Est

MEDICAL CERTIFICATION

20. DATE OF DEATH

4-6 1946 21 107

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-1 1946 to 4-6 1946

and that I last saw him alive on

4-3 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

7

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clifford E. Schott M. D. or other

Address Berlin MD Date signed 4/8/46

